Maryland CANCER FUND

Consent Form for Treatment
[Program] [Health Department]

The Maryland Department of Health and Mental Hygiene (DHMH) distributes grants for the Maryland Cancer Fund to the [**Program**]. The funds for this program are provided by the Maryland taxpayers who donate money through the state income tax check off system.

You must read, sign and date this form so that [Program] may pay for your [type of cancer] treatment or diagnostic workup.

- I authorize doctors and other medical providers (including laboratories and radiology facilities) to give the results of my screening(s), laboratory test(s), surgical consultations, biopsy(ies), cancer size and stage, treatment recommendations (if applicable), and/or operations related to cancer screening, diagnosis, and treatment to the [**Program**]. I further authorize doctors and other medical providers to give to the [**Program**] information from my medical history about past cancer screenings, diagnoses, and results. I also authorize the [**Program**] to share medical information with the DHMH.
- I understand that if I am found to need more tests to diagnose a finding suggestive of cancer identified during diagnostic services, the [**Program**] will pay for these tests using the Maryland Cancer Fund – Cancer Treatment Grant.
- I understand that the [**Program**] will pay for future visits, tests, and procedures to treat my [**type of cancer**] under the Maryland Cancer Fund – Cancer Treatment Grant funding to the extent of available funds--$[**amount of award**].
- I understand that if I need additional tests or treatment that cost more than the $[**amount of award**], the [**Program**] will not be able to pay for these services. A doctor, hospital, or other care program may bill me for tests or treatment.
- I understand that the information I provide and the results of my [**type of cancer**] tests or treatment will be kept confidential by the [**Program**] and the DHMH. Information will be used for statistical, clinical, and program management purposes only. I may inspect, amend, and correct the information on my records. Information will not be disclosed again to others except as allowed or required by Maryland or Federal law.

This consent form is valid for one year from the date it is signed. I have read the about statements and agree to them.

_____ _____

Date Name

_____

Signature